DWS-SDS
DOH-BES
Form 24 8/00

Medical Transportation and Lodging Request

Utah Department of Health

Part 1	Case Name:	Case #	Date
Name of Person Requiring Travel:			

Part 2	Complete this section for each date of travel			DWS/BES office use only.		
Date of Travel	Name and Address of Medical Provider	Total Mileage	[1] Overnight Expenses	[2] Mass Transit Available? Y/N	[3] Care outside the recipient's local area? Y/N	Covered Service Y/N
Totals				**Total Mileage x .18 = $**		
				Mileage and Overnight Expense Total $		

Recipient Signature _____

Part 3 For Office Use Only

Date Received:	Approved **9** Denied **9** Reason:_____	# of Miles_____ x .18 =_____ + Lodging Expense_____ Total Expense Allowed_____
Counselor/Worker Name:		

1 The recipient must travel more than 100 miles and driving time would result in arriving home later than 8:00 p.m. or the medical services requires an overnight or extended stay. Attach bills and Dr.'s statement. (651-4)

2 Reimbursement is available only if adequate mass transit is not available or the recipient is unable to use transit because of a disability, cost effectiveness, or having small children. (651-4 pg10)

3 Reimbursement is allowed to get medical care outside the recipient's local office area ONLY if the recipient cannot get Medicaid care locally. (651-4 pg12)